

THE

# LOUISVILLE MEDICAL NEWS.

"NEC TENUI PENNA."

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SATURDAY, JUNE 9, 1883.

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## Original.

### RUPTURE OF ABDOMINAL CYSTS.

BY W. SYMINGTON BROWN, M.D.\*

The large majority of so-called ovarian tumors are intimately connected with an ovary, probably commencing in a swollen Graafian follicle, but a certain portion, larger than was at one time supposed, arise from the parovarium and have no direct connection with the ovary. These latter are commonly called "dropsy of the broad ligament."

Mr. Lawson Tait (British Medical Journal, Oct. 28, 1882) reports "one hundred consecutive cases of ovariectomy performed without any of the Listerian details," of which number only three died, and of these three one was fatal by accidental suffocation. In two cases the disease turned out to be solid fibroma of the left ovary. In ninety-eight cases the disease was cystoma; and of these latter the tumors in eleven cases were parovarian. Mr. Tait estimates that parovarian cysts constitute about ten per cent of such operations.

Dr. Gallez, of Brussels, has written an exhaustive work on ovarian cysts, in which he devotes a chapter to rupture.† He says [freely translated and abridged]:

"One of the spontaneous terminations frequently occurring consists in rupture of the cyst. Rupture has taken place without previous inflammation solely by distension of the tumor, a cure following in consequence, as related in the observations of Bonfils de Nancy, Camus, etc. Kiwisch cites cases where the rupture was followed two or three times by re-accumulation of the liquid, ending in recovery.

\*Read before the Gynecological Society of Boston, 1883.

†Histoire des Kystes de l'Ovaire. Par Louis Gallez, M.D. Bruxelles, 1873.

"Under similar circumstances we find the cyst to rupture by some extraordinary cause, as a collision, a blow, a fall, etc., and also in a fit of laughter, sneezing, violent coughing, or a sudden movement. The woman seen by Boinet and Hupier received a kick on the belly, and was radically cured by rupture of the cyst. A woman carrying a still larger cyst made a false step, the tumor burst into the peritoneal cavity, which became inflamed, but the cure proved radical. A patient of Gautier fell on the edge of a chamber-pot, the cyst ruptured and did not refill.

"The contraction of the abdominal muscles and diaphragm, under the influence of vomiting, as related by Eager, sufficed to produce rupture and cure of an ovarian cyst. A woman carried a cyst of the right side for seven years. She fell on a stairway and struck her belly. Some time after she had a strange sensation in the abdomen and a frequent desire to urinate, passing four and a half pounds within twenty-four hours. This diuresis continued ten days, after which no traces of the tumor could be found. There was great debility and emaciation, which a tonic remedy soon removed.

"Spontaneous rupture of these cysts might occur without being noticed by the patient. Koeberle says the accident is not always accompanied by grave symptoms."

Dr. Goodell, of Philadelphia, contributes a paper on this subject ("Bursting Cysts of the Abdominal Cavity") in the sixth volume of the Transactions of the American Gynecological Society. He gives details of three cases, which I abridge:

"CASE I. The patient was forty-six years old, had been married for twenty years, and had three children. Two years ago [since 1879] she discovered an abdominal tumor as large as her two fists. About a month ago it began to grow rapidly, and it now reaches the navel, giving her a very painful

sense of bursting. Dr. Goodell aspirated it September 25th, and removed about eight quarts of a reddish fluid stained with blood. November 8th he went to her house, and found her suffering from colicky pains, and the tumor not to be discovered. For a few days there was an unusual secretion of urine. February 13, 1880, the sac again burst spontaneously. During the summer of that year it burst twice, besides being aspirated, and on December 18th he removed the tumor by abdominal section, and the lady soon got well.

"CASE II. In 1874 an unmarried lady, aged twenty-two years, came under the care of a regular female physician, who diagnosed the presence of an ovarian tumor, which afterward burst twice. Early in January, 1881, Dr. Goodell found lying in front of the womb a cystic tumor as large as a Florida orange. He removed it through the abdominal walls in March, and the patient recovered."

"CASE III. December 18, 1880, Dr. Goodell was consulted by a lady, aged twenty-five years, who had been married eighteen months without conceiving. Behind the womb, in Douglass' pouch, lay a movable painless cyst as large as a lemon. On February 3, 1881, he found that the cyst had disappeared, and left in its place a rugous body as large as an almond. When she called, June 24th, the rugous body had been converted into a cyst the size of an apple. On September 5th the cyst had again disappeared; it must have burst two days before. At a visit on September 14th, it was evident that the cyst was again filling up. But while Dr. Goodell was outlining and pressing it by conjoined manipulation, it suddenly burst under his fingers. He has not seen the case since."

The following case occurred in my own practice recently:

Mrs. Blank, sixty years old, has had two children, the second one twenty-five years ago. The menstrual flow had always been regular and painless. The menopause occurred fifteen years ago. She had an attack of diphtheria in 1873, and has not been so well since then. Her external circumstances have uniformly been as favorable as ample money and the kindness of a devoted husband could make them. She lives regularly, eats moderately, and abstains totally from intoxicants. She complains of pain in her right side, extending downward. After continuing for several weeks, the pain abated for one week and then returned. Is troub-

led by dysuria. She passes a small quantity of high-colored urine at a time, repeated at short intervals for several days; followed by larger quantities of clear urine for a variable period. The pain is more severe when the urine is high colored. Appetite fair, sleeps pretty well at night. The pain in the right side is increased after riding in a carriage.

May 31, 1882. A careful bimanual examination revealed the presence of a sac on the right side, in which fluctuation could readily be detected. That same afternoon a consultation was held with Dr. James R. Chadwick, of Boston, who confirmed the diagnosis of ovarian tumor. The following are the measurements subsequently taken, immediately below the umbilicus:

June 5, . . . . .	33 inches
" 20, . . . . .	35 "
July 9, . . . . .	37 "
" 12, . . . . .	39 "
" 14, . . . . .	40 "

On the 17th of July Mrs. B. went to Boston and had an external application of galvanic electricity. She had had several such applications on previous days. On alighting from an open horse-car she made a misstep, and afterward rode and walked more than usual that day. During the next morning, about two o'clock, she was attacked with an agonizing pain, which continued fully an hour, and was finally relieved by very hot fomentations. During that day and the following one she passed more than four quarts of high-colored urine each day; amount continued much larger than usual for several days. The sac had evidently burst. Before this occurred she had been unable to tie her own shoes. Two days later she measured only thirty-five inches below the umbilicus, and within a week the tumor could not be felt. Since that time her general health has improved, and, at this date (May, 1883), there is no sign of re-accumulation.

Several cases are on record in which the sac filled again, or a new sac formed after the lapse of two or more years. When the rent is sufficiently large, fluid may continue to be secreted, but it passes into the peritoneal cavity and is absorbed.

STONEHAM, MASS., May, 1883.

THE honorary degree of L.L.D. of Cambridge is to be conferred on M. Pasteur, Sir John Lubbock, and Professor Roscoe of Owens College, Manchester.

### Miscellany.

**PRESCRIBING DRUGGISTS.**—Another death from chloral once more exhibits the fatal ease with which the public, in spite of a Sale of Poisons Act, can procure dangerous drugs from prescribing chemists. Last week a young man, twenty-two years of age, the subject of melancholia with suicidal tendency, applied to one of the leading pharmacists of Birmingham, complaining of pains in his head and sleeplessness, and asking for some chloral to make him sleep. The druggist explained at the inquest that he "advised deceased to try and do without narcotics," but he did not advise him, as he ought to have done, to consult a medical practitioner, and he at once supplied to him, as he ought not to have done, a very dangerous quantity of a solution of hydrate of chloral. The druggist very improperly prescribed for, and supplied to the intending suicide, a mixture containing one hundred and twenty grains of chloral hydrate, with directions that the twelfth of the whole was to be taken for a dose. The young man took the mixture home, wrote a farewell to his friends, swallowed the whole of the poison, and was found next morning dead in his bed. Neither the coroner nor his jury appear to have made any comment upon the conduct of the druggist; no one was blamed, and the stereotyped verdict of suicide whilst in a state of temporary insanity was returned. The death of this young man was clearly preventible. The deceased was suffering from a form of unsoundness of mind, which was possibly curable, and which rendered it necessary that he should be efficiently prevented from injuring himself. The death of this suicide might have been prevented if a dispensing druggist had refrained from prescribing for serious illness, and from supplying to the deceased, without any authorization, a poisonous quantity of a dangerous drug.—*Brit. Med. Jour.*

**VEGETARIANISM.**—Mrs. Norman Kerr recently entertained about one hundred employes of the Vestry at a vegetarian supper at the Walmer Castle Coffee Tavern. There were also present Dr. B. W. Richardson, and Dr. W. Blyth. The dinner consisted of "hotch-potch" soup, which was much like Scotch broth, a savory pie, a "sweet," cocoa, and bread, and the cost was calculated at 3d. per head. For the "hotch-potch" soup the materials were two bunches

of turnips, which cost 8d.; one bunch of carrots, 4d.; two bunches of leeks, 6d.; two heads of celery, 5d.; six pounds potatoes, 6d.; one pint of green peas, 2d.; parsley, 3d.; and half pound butter, 7d., making a total cost of 3s. 5d. There were six loaves of brown-bread, at 9d. per quarter loaf, costing 4s. 6d. For the savory pie, the materials were two and a half gallons of haricot beans, at 2d. per quart, 1s. 8d.; fifteen pounds flour, at 7d. per quarter, 2s. 6d.; six pounds onions, at 1d. per pound, 6d.; and one half pound butter, at 1s. 2d. per pound, 1s. 9d.; costing altogether 6s. 5d. For the "sweet," there were used seventeen pounds rice, at 2d. per pound, 2s. 10d.; seven bunches of rhubarb, 2½d. per pound, 1s. 5½d.; and ten pounds sugar, at 2½d. per pound, 2s. 10d.; making the cost 6s. 4½d. For drink, there were supplied one hundred cups of coffee, at one half-penny per cup, costing 4s. 2d. The total cost for one hundred persons was thus, £1 4s. 10½d., or 3d. for each person. The object was to show how cheaply a nourishing meal might be provided. Apologies were read from Lords Waldegrave, Claud Hamilton, and Mount-Temple (who stated that Lady Mount-Temple had been a vegetarian for many years), Mr. Ernest Hart, and Sir Patrick Colquhoun (who sympathized warmly with vegetarian diet, and practiced it when in his own house).—*Ibid.*

On Wednesday last, at University College Hospital, Mr. Christopher Heath made use of Junker's anesthetic apparatus in a case of excision of the jaw. Some little difficulty in getting the patient under the influence of the anesthetic was met with, but anesthesia was subsequently easily maintained throughout the operation. The narcotized air was delivered at the back of the pharynx through an ordinary gum-elastic catheter bent to the required form. About two and a half drams of chloroform were used in twenty-five minutes. The convenience of the apparatus to the operator was manifest.—*Ibid.*

**CONSULTING-ROOM TALK.**—"How long will it take you to cure me, doctor?" "Well, Mr. Blank, I think you can get back to your desk at the bank in about a month, but you will have to take treatment for several years." "But you mistake; I am not Mr. Blank the banker, but Mr. Blank the letter-carrier." "Oh, indeed, that alters the case, you are quite bilious, but you will be well in a month!"

**MONSIEURS PASTEUR AND PETER.**—The Medical Press' Paris correspondent writes: "The greater part of the séance of the *Académie de Médecine* last week was occupied by M. Pasteur, who came up expressly from the country in order to defend himself from the allegations of M. Peter, who at a former meeting showed himself antagonistic to the theories of the celebrated discoverer of microbes. In a lengthy communication, M. Pasteur endeavored to refute the opinions of his adversary, and denied that his vaccinations were attended with fatal results. He reproached M. Peter with being entirely ignorant of the subject in question, and added, 'I am not a doctor or even a veterinary surgeon, and I often regret it. If I were younger, or even as I am, if I had better health, you would see me on the seats in the gallery. When I obtained the honor of being called to this Academy, I rejoiced in the idea that I was going to learn from you many things of which I was ignorant, but I consoled myself with the thought that the path I had chosen, although deviating a little from the well-beaten road of medical science, would perhaps contribute its share, however small, to the benefit of that science. To hear my learned friend talk with such contempt of chemists and physiologists who touch the question of diseases, one would think that he was speaking in the name of a science whose principles were founded on a rock. Did he want a proof of the little advance that is made in therapeutics? He will find it in the fact that for the last six months a discussion is going on as to whether typhoid fever should be treated by this or that method, or not at all. And when on the eve of solving the question of the etiology of this disease by the microbia, M. Peter has the audacity to cry out, 'What do I care about your microbes!' M. Peter thinks that because I turned my mind to chemistry, physics, and physiology, I should know nothing; but a labor of forty years permits me to defy such insinuations. I glory in one thing, and that is, that the great discovery of the attenuation of virus (charbon) by vaccine can be considered as wholly French.' (Prolonged applause.)"

**THE SPLEEN AS A BLOOD-PRODUCING ORGAN.**—Dr. Korn has conducted a number of experiments to determine the part played by the spleen and bone-marrow in the formation of red-blood corpuscles. (*Deutsche Med. Woch.*) He practiced repeated small blood-lettings upon pigeons. Changes in

the blood after this procedure were constant. It became of a darker color, clotted more readily, and contained a greater number of white corpuscles. The bone-marrow was more red, contained less fat, but presented a very large number of undeveloped red-blood corpuscles. These results were the same whether the spleen had been extirpated or not. When present, this organ was anemic. Dr. Korn concludes from these experiments that the spleen performs no function in the reproduction of red-blood corpuscles in birds. And in this he is in agreement with Neumann, who has arrived at the same conclusions in respect to animals.—*The Medical Record.*

**SYPHILIS IN THE NINTH CENTURY.**—Between the years A.D. 806 and 810, an Emperor of Japan commanded his court physicians, Abemamas and Idzumo Kirosada, to collect in one volume all extant records of native medicine and surgery. (British Medical Journal.) A manuscript copy of this work, for centuries forgotten, although the facts of its origin were recorded in Japanese history, was found in 1827, by a priest, in a provincial Buddhist temple. Dr. Scheube, of Leipzig, has recently examined this work, and, in an article published in a recent number of Virchow's *Archiv*, has shown its undoubted authenticity and its high value from a purely scientific point of view. It was written long before Chinese ideas had penetrated into Japan and influenced native practitioners. The most interesting passages are descriptions of local and general affections, which clearly prove that syphilis and several allied disorders were well known to the ancient Japanese. Chancroid and phagedenic chancre are clearly described, as well as a "swelling on the penis, of the size of a millet seed," followed by eruptions, feverishness, pains in the bones and head, blindness, swelling of the testicles, and other very familiar symptoms. These were observed to continue for many years. The passages of this work, called the Daidorui Thiu-ho, which relates to the treatment of these symptoms, have not yet been translated into English. Herbs alone appear to have been used, and without much success; mercurial treatment was introduced at a comparatively recent date, from Europe. The ancient Japanese surgeons do not appear to have recognized the venereal origin of the disease which they describe, although the Daidorui distinctly traces all the secondary symptoms to "the poison from the affected organ."



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L. S. McMURTRY, A.M., M.D., - - - } Editors.

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### LARYNGEAL EPILEPSY.

At the recent meeting of the American Laryngological Association, Dr. George M. Lefferts, of New York, reported a very remarkable case of laryngeal disease. A young and apparently healthy man, while sitting at the table, became suddenly unconscious, fell, and almost immediately arose and resumed the conversation. The attack had been frequently repeated during the past eight years, and was always preceded by a slight cough, the face became suffused, but no convulsive movements were apparent. The laryngoscope revealed nothing abnormal beyond slight hyperemia. By some this condition has been termed laryngeal vertigo, while by others it is known as laryngeal epilepsy. Dr. Lefferts very pertinently inquires if there is a definite relation between the tickling in the throat and the fall and unconsciousness. It is interesting to note with what readiness the members of the association localized the disease in the larynx, thus illustrating the growing tendency of special investigation. The general practitioner, we imagine, will have little difficulty in recognizing in the symptoms of this new disease of the laryngologist a familiar form of epilepsy. Under the name of *petit-mal*, cases so similar in character are described by Trousseau as to leave little

doubt of the identity of pathological character. The introduction of such terms as laryngeal epilepsy for such conditions tends to complicate the study of disease instead of promoting its facility.

### REDUCTION OF DISLOCATIVE FEMUR.

Dr. Samuel Logan, of New Orleans, has recorded in a recent paper additional experience in confirmation of the plan proposed by him several years since for reducing, by manipulation, luxations of the femur. The difficulty incurred by the usual methods, according to the late Mr. Callender, of London, consists in the slipping of the head of the femur around the rim of the acetabulum during the ordinary process of manipulation, thus lodging the head of the bone in the thyroid foramen. Dr. Logan obviates this difficulty by making use of the anterior border of the pelvis as a fulcrum, and in that way lifting the head of the femur over the rim of the acetabulum with the thigh flexed upon the abdomen; the limb at the junction of its upper and middle third impinges upon the pelvis just below the anterior superior spine of the ilium. Forced flexion lifts the head of the femur, and rotation will throw the bone into place. The observance of these suggestions will be found of value in the reduction of this important class of injuries.

**RHEUMATISM.**—The subject of rheumatism being under discussion lately in Melbourne in the secular press, a great variety of opinions were expressed by leading citizens. Among others the Rev. Dr. Bromby declared it as his belief that rheumatism is caused by tea-drinking. He drinks tea, and he has rheumatism, therefore he believes the rheumatism is produced by the tea. He *thinks* that after drinking tea his rheumatism is worse. Therefore he believes the tea aggravates it. This is a fair specimen of the average theologian's medicinal views.

### Bibliography.

**A Manual of Auscultation and Percussion**, embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism. By AUSTIN FLINT, M. D., Professor of the Principles and Practice of Medicine and of Clinical Medicine in the Bellevue Hospital Medical College, etc. Third edition revised. Philadelphia: Henry C. Lea's Son & Co. 1883. 12mo. Pp. 242.

This excellent manual has been in the hands of the profession so long, and is so favorably known, as to scarcely require critical notice at this late day. Prof. Flint is known to be a master in the art of auscultation and percussion, and his long experience as a clinical teacher enables him to present the subjects treated herein with ease and simplicity. No better proof of its acceptability could be given than the fact that it has reached its third edition. Originally prepared as a class manual, embodying the substance of the author's lessons to private classes, it has grown through successive editions to a handsome volume of two hundred and forty-two pages. At the same time it is still a manual, restricted to auscultation and percussion, and condensed in style and arrangement. In this latest edition the author has introduced some practical points not contained in previous editions, and has described the modes by which pulmonary signs may be produced in the lungs when removed from the body, and by artificial means.

It is scarcely necessary to add that the publishers have made of this manual a handsome book. The Messrs. Lea are so well known to the profession in this regard that comment is unnecessary.

**FEMALE MEDICAL STUDENTS IN PARIS.**—From a report furnished by M. Béclard, Dean of the Medical "Faculté" at Paris, to the Vice Rector there, it appears that the number of women following the profession as regular students, *i.e.*, those who have produced two diplomas, of bachelor of letters and science, or, if foreigners, certificates equivalent thereto, is thirty-nine during the past two years—ten French, eleven English, five American, nine Russian, one Hungarian, one Polish, one Roumanian, one Indian.—*Med. Press.*

PROF. WILLIAM E. QUINE has resigned his chair in the Chicago Medical College, and has accepted the chair of Practice of Medicine in the College of Physicians and Surgeons, of Chicago.

### Medical Societies.

#### **PATHOLOGICAL SOCIETY OF PHILADELPHIA.**

The Pathological Society of Philadelphia met Thursday evening, May 24, 1883, the president, Dr. Tyson, in the chair.

*Carcinoma of the Stomach and Colon with Cardiac Lesions.* Exhibited by Dr. J. T. Eskridge.

Peter Lawler, aged sixty years, Irishman, by occupation a dyer, was said to have enjoyed fair health until two years ago, when he suffered from a severe attack of inflammatory rheumatism. He knew but little of his family history, and could not give the cause of his parents' death. He never complained of heart disease. During the latter part of the year 1881, about eighteen months before his death, he first began to complain of pain in the epigastric region, attended by eructations of a sour, slimy liquid. Soon he experienced a sense of nausea coming on an hour or more after eating. About three months after the first appearance of symptoms of gastric disease he began to vomit. At first vomiting occurred occasionally, but soon it took place several times a week, and finally once or twice each day. He lost flesh rapidly. In the early part of March, 1883, he was admitted into the wards of the St. Mary's Hospital, when he came under my observation for the first time. He was very weak and greatly emaciated. His pulse, of the Corrigan type, was 80 per minute. When resting in the recumbent posture his breathing was quiet. Temperature was usually one degree below normal. The radial and temporal arteries were rather hard, and the latter were tortuous. A diastolic murmur and a systolic murmur were heard at the aortic orifice. The impulse of the heart was not very strong, and the left ventricle did not appear to be greatly enlarged. The lungs were emphysematous, and an area of impaired resonance, amounting to almost dullness, was discovered on each side of the spinal column, opposite the spines of the scapulæ. An indurated mass, apparently about the size of a walnut, more or less movable, was felt in the epigastric region to the right of the median line, and about midway between the ribs and the umbilicus. The growth was not sensitive to rather rough manipulation, and he had not experienced any pain for a number of months. His bowels were sluggish, and it required active

agents to evacuate them. No tumor besides the one connected with the stomach was felt or suspected in any other portion of the abdomen. He vomited almost daily. The liver and spleen were not enlarged. The urine was free from albumen.

By securing daily evacuations from the bowels, and giving him nutritious, easily assimilated food, the vomiting nearly ceased. He improved, and left the hospital the latter part of March. Early in April he was admitted to the Jefferson Medical College Hospital, where he came under my care the 1st of May. At that time he was eating but little, the abdomen was considerably distended by gas, and his bowels required repeated large enemata or enormous doses of purgatives to secure their action. On the 4th of the present month he experienced great pain in the right iliac region, and just to the right of the median line of the abdomen, midway between the pubes and umbilicus. Over and around the latter painful spot a circumscribed highly tympanitic and sensitive area, about the size of a man's double fist, was observed. Circumscribed peritonitis was diagnosed. Large doses of morphia, administered hypodermically, were required to relieve pain. The stomach became irritable and the peritonitis more general. He died during the afternoon of the 8th of May.

*Sectio cadaveris*, four hours after death, by the pathologist of the hospital, Dr. Morris Longstreth:

*Thorax.* About seven ounces of perfectly clear serum were found in the pericardium. No evidence of pericarditis existed. Left side of heart firmly contracted; right side relaxed and contained considerable fluid blood. Right side of heart and its valves normal. No lesion found at mitral orifice. Free borders of the leaflets of the aortic valve are thickened and slightly contracted, allowing regurgitation to take place at the aortic orifice. Aorta atheromatous, dilated, and decidedly roughened near the aortic orifice. Left ventricle slightly hypertrophied. Lungs deeply pigmented, and generally emphysematous; both congested posteriorly. Surfaces of both apices covered with patches of fibroid thickening. Abundant evidence of diffuse peribronchitis chronica was present. Bronchial tubes of the lower lobes of both lungs much dilated. Bronchial glands at the root of the lungs very much enlarged.

*Abdomen.* On opening the abdominal cavity considerable very offensive gas escaped from the upper part. On the right

of the median line of the abdomen, from the umbilicus downward, the abdominal wall anteriorly was adherent to omentum and intestine over an area of about five inches in diameter. Lower third of abdominal cavity was filled with a yellowish-white, cloudy liquid. The intestines were bound together by numerous adhesions. The stomach, which I show you, is small, and its coats are thickened. The hypertrophy of the wall of the stomach is slight at the cardiac end but, gradually increasing, becomes considerable at pyloric. The wall of the pylorus and adjacent portions of the stomach and small bowel is about one half inch thick. At this point the mucous surface presents several fungous-looking outgrowths. The small bowel, with the exception of about half an inch of the upper portion of the duodenum, appears normal. In the colon, about six inches from the ileo-cecal valve, is a stenosis barely admitting the end of my little finger. The wall of the colon at the point of narrowing, which extends three or four inches of the length of the bowel, is greatly hypertrophied, measuring about one third of an inch in thickness. The colon, from its beginning to point of constriction, is dilated into a large pouch, measuring four and a half inches in diameter. The dilated portion of the bowel presented a dark gangrenous appearance, distended by gas; was adherent to the anterior wall of the abdomen, just to the right of the median line. The remaining portion of the large bowel appears to be healthy. No enlargement of the mesenteric glands was observed. Liver, spleen, and pancreas were small and firm, but free from malignant growths. Both kidneys were reduced in size; contained a few small cysts. Their cortical substance was lessened, and their capsules were abnormally adherent in places.

*Remarks.* It is worthy of remark that, although considerable thickening and induration existed at the pyloric end of the stomach, the orifice remained sufficiently patulous to allow the food to come in contact with the intestinal juices. Another point of interest is seen in the existence of so great amount of narrowing in the caliber of the large bowel with no symptoms, except easily obviated constipation, until a short time before the man's death. It seems to me remarkable that a bowel so dilated above the point of a narrow constriction should be able to respond painlessly to purgatives.

*Mitral Stenosis and Regurgitation formed by Tricuspid Regurgitation and General Dropsy.*  
By J. T. Eskridge, M.D.

Ellen D., forty-eight years old, single, servant, was born in Ireland. Her mother died from some chest trouble when about forty years of age. Her relatives were subject to "pleurisies and rheumatism." Her father lived to an advanced age. Ellen enjoyed good health until six years ago, when she suffered from three attacks of rheumatism within a few months. During each attack she was lame in her feet and legs. After those rheumatic seizures she was comparatively comfortable until the early part of the year 1879, when she noticed that going up and down the stairs or prolonged or active exercise exhausted her more than usually, and gave rise to palpitation of the heart. In the year 1880 she had another slight attack of rheumatism. She said her feet were almost constantly swollen during the years 1881 and 1882. Last summer her general health improved, but when the cold weather of the following fall and winter set in, increasing dropsy and dyspnea returned. She was admitted into the wards of the St. Mary's Hospital December 5, 1882, suffering greatly from general cardiac dropsy and associate symptoms. One month later it was noted that she temporarily improved after admission, but the dropsy re-occurred, and she failed rapidly.

January 10, 1883, her condition was observed to be as follows: She was jaundiced, irritable, and morose. She dozed frequently. Her mind seemed clouded, but she was very restless. The tongue was heavily coated, breath had an offensive urinous odor, stomach was irritable, and anorexia almost complete. The urine was diminished in quantity, and contained abundance of albumen. Effusion existed in each pleural cavity, slight in the right, but the left side was filled up to the lower angle of the scapula. The pericardium contained an increased quantity of liquid. The lungs were congested, and numerous moist bronchial râles were present. Arterial pulsation was seen only in the carotids. Visible venous pulsations were very pronounced in the veins of the neck, and in one or two superficial veins on the anterior surface of the chest. After emptying the veins and exerting pressure upon them they were observed to fill from the cardiac side and again pulsate while the finger was still firmly held against the vessels. A wavy

impulse extending over a large area was seen. The cardiac pulsation was most marked just below the lower end of the sternum. The pulse was very irregular and difficult to count, being about 120 per minute. It was intermittent, and irregular in volume and frequency. The variations of the pulse were most prominent when the hands were raised above the head. The impulse of the heart was felt over a large portion of the anterior surface of the chest. The area of the cardiac pulsation was bounded on the left by a point in the fourth intercostal space external to the left nipple, on the right by a point one inch internal to the right nipple, below by a point two inches below the sternal notch, and above by the left second intercostal space. Hepatic venous pulsation was very distinct. Percussion dullness was increased most on the right side. The pulmonary and aortic valves were apparently free from disease. A presystolic murmur, with its seat of intensity over the left fourth costo-sternal articulation, was heard. A systolic murmur, whose seat of intensity was over the left fifth costal cartilage, was heard over the anterior surface of the chest from nipple to nipple, and in the left axilla. It was difficult to determine whether the murmur was audible posteriorly, as the bronchial and crepitant râles and rapid breathing were confusing. Four or five days later the presystolic murmur ceased to be audible. At that time general anasarca was well pronounced. January 24th she went into a semi-conscious condition, which gradually deepened into coma. She died January 26th. She expectorated considerable blood and frothy mucus during the last month of her illness. Sectio cadavaris twenty-four hours after death. Body well frozen. Considerable adipose tissue still remained. Thoracic and abdominal cavities only examined.

*Thorax.* Left pleural cavity almost completely filled with a thin, straw-colored, serous fluid, right pleural sac nearly half full of a similar effusion. Were no pleural adhesions. The left lung was crowded into a small space, and congested; the lower lobe sank in water. The right lung was being encroached upon by the effusion, and its lower lobe was consolidated; the upper emphysematous.

*The pericardium* contained about six ounces of fluid similar to that found in the pleural cavities. No adhesions or patches of fibrinous exudations were seen on the



surface of the heart. The cavities of the heart were relaxed and filled with dark fluid blood. The right auricle is greatly dilated. The tricuspid orifice admits the ends of the thumb and all the fingers of one hand up to the distal joint. The right ventricle is dilated, and its wall is thickened. The tricuspid valve is insufficient. The valves at the pulmonary and aortic orifices are thin, but competent. These orifices are not constricted. The wall of the left ventricle seemed to be thickened, and the ventricle is slightly dilated. The left auricle is greatly dilated. The curtains of the mitral valve are adherent to each other near their attached borders, and constrict the orifice, which they are no longer able to close, into a round opening only large enough to admit the end of the index finger.

*Abdominal Cavity.* The blood-vessels of the stomach and bowels distended. The mucous membrane softened. Liver heavy, dark, and grated under the knife. Spleen enlarged, congested, and denser than normal. Pancreas healthy. Both kidneys were congested, slightly cirrhotic, but contained considerable functioning tissue.

General dropsy is rare in cases of mitral stenosis, except, as in the present instance, where it is combined with mitral insufficiency. No thrill was present during my attendance, which extended over a period of four weeks immediately preceding her death. The mitral presystolic murmur ceased to be audible during the last two weeks of her life. The absence of the presystolic murmur in cases of extreme stenosis of the mitral orifice, late in the disease, when the heart is weak and is acting rapidly and irregularly, has led some observers to believe that the murmur is frequently absent throughout the course of this form of valvular lesion. To this point I directed special attention in a recent paper on the "Diagnosis, Prognosis, and Treatment of Mitral Stenosis," read at the last meeting of the Pennsylvania State Medical Society.

*Congenital Malformation of the Heart with Cyanosis; Death at the age of twenty-nine years from Pulmonary Tuberculosis.* Dr. J. T. Eskridge gave a detailed account of the above case. The patient, a man twenty-nine years old, had never been strong and able to run and play like other boys without suffering from severe palpitation of the heart. So far as the man could remember, he did not become blue before his twelfth year. After the occurrence of cyanosis his health

was much worse. He had rarely experienced pain in the region of the heart. One year ago he first observed pains shooting through the upper portion of the right side of the chest. These continued, and at times were severe, being sharp and lancinating in character. From the first appearance of the pains he began to lose flesh and strength. About the time of the beginning of the chest pains a dry, hacking cough commenced, but expectoration was not profuse until a few weeks before he first saw him, when he took a heavy cold, which was followed by high fever, great prostration, and profuse night-sweats. He was admitted to the St. Mary's Hospital January 2, 1883. The surface of his body presented a dusky hue, and his face, neck, hands, and feet (especially the fingers and toes) were quite blue. When he sat up, the blue color of the mucous surface of the lips deepened into dark purple. The distal phalanges of the fingers and toes were hypertrophied, and the small superficial veins of the face, fingers, and various other portions of the body were easily seen and counted. The upper lobe of the right lung was consolidated, and contained a cavity; the lower lobes were partially infiltrated. In the left lung the lower lobe was solid, and the left was being infiltrated. Over the left lung pleuritic friction râles were numerous.

No venous pulsation was discovered. A presystolic thrill was felt in the third and fourth intercostal spaces to the left of the sternum, and was barely appreciable in the third intercostal space at the right border of the sternum. Percussion dullness was increased laterally. The cardiac impulse was felt and seen in the fourth intercostal space external to the left nipple.

A systolic and a presystolic murmur, with their seats of intensity near the left fourth costo-sternal articulation, were heard. The systolic murmur was audible anteriorly over a large area, and posteriorly at the lower angle of the left scapula. Anteriorly the systolic murmur was heard as low as the seventh rib on each side of the sternum, faintly just below the left clavicle, but it was lost just below the right clavicle. The systolic murmur was audible in the left axillary region, but not in the right. The presystolic murmur was limited to a small area.

The next three days the temperature varied from 100° to 102.5°. On the 6th he coughed up several mouthfuls of blood unmixed with mucus. From the 7th to 11th was profuse expectoration of purulent matter containing small quantities of blood.

Breath was very offensive, and the apex of the right lung was breaking down rapidly. Diarrhea was rebellious and exhausting. He died suddenly on the morning of the 12th.

Post-mortem examination was made about four hours after death. The lungs were infiltrated by tubercle. The left pleural cavity had been obliterated by general pleuritic adhesions; the right contained about three pints of sero-sanguinolent fluid.

*Heart.* Numerous pleuro-pericardial adhesions were present. The pericardium was not inflamed on its internal surface, and was nowhere adherent to the heart, but it contained about two ounces of a straw-colored serous fluid. The heart was anemic, flabby, and dilated. Its cavities contained a small quantity of fluid blood. No heart-clot had formed. The right auricle, including its appendix, was enormously dilated. The right auricular wall was somewhat thickened. Across this auricle a thin membranous slip stretches from right to left, and from above downward. Its attachment above was at the upper portion of the auricle to the right of the appendix; below at the left margin of the tricuspid orifice. The imperfect septum, he thought, had been an attempt by nature to divide the auricle into two nearly equal compartments. The inter-auricular septum was imperfect, the foramen ovale being sufficiently patulous to admit the passage of his thumb from the right auricle into the left. The right auriculo-ventricular orifice was enlarged, and admitted the ends of the thumb and all the fingers of one hand. The right ventricle was dilated to nearly twice its normal size. Its wall was not much thickened. A patch of fibroid induration, one inch long by half an inch wide, was seen on its endocardial surface. The anterior and posterior segments of the tricuspid valve were united and formed one large leaflet. The left segment was so situated that it could not have aided materially in closing the auriculo-ventricular orifice. The greater portion of the imperfect segment was stretched across the ventricle near the apex of the heart, and more or less obstructed the current of blood from the ventricle into the pulmonary artery. Free regurgitation at the tricuspid orifice was permitted on account of the large size of the orifice and the imperfect condition of the valve. The other valves of the heart were thin, but competent. None of the orifices of the heart were constricted. The left cavities of the heart were rather small. The pulmonary artery was smaller than normal.

No special disease besides a fatty condition of the liver was seen in the abdominal organs.

In his remarks on the case Dr. Eskridge said that the membranous strip which extended across the right auricle vibrated with the auricular current of blood, and probably had given rise to a presystolic murmur. If the blood, in struggling through the patulous foramen ovale, had given rise to a murmur, it also would have been presystolic in time. He stated that the presystolic murmur in the case was well defined, and easily distinguished from the systolic one, and thought it was unfortunate for the science of physical diagnosis that both these conditions existed in the same heart. He knew no means by which one would be able to attribute the presystolic murmur to one or both of them, since it was not positive whether an intra-auricular current was capable of developing a presystolic murmur. He desired that the heart should be referred to a committee of three for a fuller report on the congenital malformation.

#### THE AMERICAN MEDICAL ASSOCIATION.

The following is the list of the papers presented before the various sections of the American Medical Association at the session just closed. The attendance was unusually good, and the work done in the various sections was of superior character. In our next issue we will lay before our readers a full and complete report of the proceedings.

The programme for the first day consisted of the annual address of the president and the reading of the following papers:

Yellow Fever, by Robt. D. Murray, M.D., U. S. Marine Hospital Service. Dr. Jones, of New Orleans, La., Dr. Ketchum, of Mobile, Ala., and Prof. Henry F. Campbell, of Augusta, Ga., have been invited to follow in the discussion.

Milk Sickness, by William Morrow Beach, M. D., Ohio.

Chronic Inter-pelvic Inflammation, by W. H. Byford, M. D., Illinois.

Post-partum Polypoid Tumors, by Henry G. Landis, M. D., Ohio.

The Restoration of the Perineum by a New Method, by Henry O. Marcy, M. D., Massachusetts.

Enterotomy as a Complication in Ovariectomy or Oöphorectomy, by R. S. Sutton, M. D., Pennsylvania.

Illustration of Anatomical and Pathologi-

cal Papers, by Alfred F. Holt, M. D., Massachusetts.

Comparison of Antiseptic and Non-antiseptic Methods of Treatment, by Dudley P. Allen, M. D., Ohio.

Value of Early and Late Operations in Morbid Growths, especially Malignant, by Prof. S. D. Gross, M. D., Pennsylvania.

Treatment of Synovial Diseases by a New Method, by Henry A. Martin, M. D., Massachusetts.

Radical Cure of Hernia by a New Method, by R. A. Vance, M. D., Ohio.

On the Surgical Use of Electrolysis, by Robert Newman, M. D., New York.

Medical Education the Fundamental Fact in Medical Ethics, by Albert L. Gihon, M. D., U. S. Navy, District of Columbia.

Sanitary Disposal of Refuse, by Henry Leffman, M. D., Pennsylvania.

Paralysis of the Facial Nerve in connection with Diseases of the Ear, by Laurence Turnbull, M. D., Pennsylvania.

Hysterical Amblyopia, by J. E. Harper, M. D., Illinois.

Tonsillotomy by Écrasement, by W. C. Jarvis, M. D., New York.

Action of Nitrate of Silver on the Mucous Membrane of the Throat, by Carl Seiler, M. D., Pennsylvania.

Tumors of the Post-Nasal Space, by E. Fletcher Ingalls, M. D.

Myringitis, by C. Williams, M. D., Minnesota.

Hereditary Syphilis, by G. W. Burton, M. D., Indiana.

Cholera Infantum, by B. W. Ryan M. D., Indiana.

Pediatric Medication, by J. B. Casebeer, M. D., Indiana.

The Relation of Teeth to other Organs, by Wm. D. Kempton, M. D., Ohio.

Amaurosis Dependent on Dental Irritation, by W. W. Alport, M. D., Illinois.

Denudation or Erosion of the Teeth, by John S. Marshall, M. D., Illinois.

The programme for the second day was the reading of the following papers:

The German Theory of Disease with Microphotographic Illustrations, by W. F. Belfield, M. D., Illinois.

Mechanical Remedies in the Treatment of Skin Diseases, by John V. Shoemaker, M. D., Pennsylvania.

On a New Method of Procuring Pure Pancreatic Juice, with Exhibition of Animal, by L. B. Tuckerman, M. D., Ohio.

Sub-Involution, its Cause and Treatment, by R. Beverly Cole, M. D., California.

Post-partum Atrophy of the Uterus, by J. Tabor Johnson, District Columbia.

The immediate application of Sutures in Puerperal Laceration of the Cervix and Perineum, by E. C. Dudley, M. D., Illinois.

What Means can be judiciously Used to Shorten the Term and Lessen the Pains of Labor, by John Morris, M. D., Maryland.

Cases in Practice, by Donald Maclean, M. D., Michigan.

Comparative Value of Antiseptics, by Henry O. Marcey, M. D., Massachusetts.

Amputation Below the Knee Joint in preference to "Brisement Force" or Resection, in *certain cases* of Deformity with Anchylosis, illustrated by two cases, by Lewis Hall Sayre, M. D., New York.

Report of a case of Re-amputation at the Hip Joint; Secondary Hemorrhage on sixth day; Ligature of the primitive Iliac Artery, by John H. Packard, M. D., Pennsylvania.

Treatment for Tender Spines by Subcutaneous Incision, by V. H. Coffman, M. D., Nebraska.

A Case illustrating the Segmental Feature of Glaucoma, by H. Culbertson, M. D., Ohio.

A New Method of Examining the Throat of Children and exhibition of Tonsillotomy, by Lewis Elsberg, M. D., New York.

A Case of Round-celled Sarcoma of the Lachrymal Gland, by F. D. Keyser, M. D., Pennsylvania.

Tinnitus Aurium and the Deafness which accompanies the Different Forms of Bright's Disease, by Laurence Turnbull, M. D., Pennsylvania.

Questions on the Etiology of some Forms of Lenticular Opacity, by J. L. Thompson, M. D., Indiana.

Croup and Diphtheria, by E. L. Boothby, M. D., Wisconsin.

Epidemic Jaundice among Children, by Alexander Y. P. Garnett, M. D., District of Columbia.

Unity of Diphtheria and Membranous Croup, by A. Harris, M. D., Virginia.

First Dentition, by J. Taft, M. D., Ohio.

Myxoma of the Tongue, by C. R. Agnew, M. D., New York.

Minor but Important Points in the Operation for Hare-lip, by F. H. Rehwinkel, M. D., Ohio.

The programme for the the third day was as follows:

Vaccination and Propagation of Vaccine Virus, by H. A. Martin, M. D., Massachusetts.

Elements of Prognosis and Therapeutics of Laryngeal Tuberculosis, by Solis Cohen, M. D., Pennsylvania.

Is Croupous Pneumonia an essential Fever, and is Blood-letting demanded in its Treatment? by H. G. Sharp, M. D., Ohio.

On the Specific Treatment of Enteric Fever, by James C. Wilson, M. D., Pennsylvania.

Batley's Operation—Death from Ether, by R. Batley, M. D., Georgia.

Value of Gynecological Treatment in Hysteria and Allied Afflictions, by P. Zenner, Ohio.

On the Midwifery and Gynecology of the Ancients, by G. M. B. Maughs, M. D., Missouri.

Excision of both Hip Joints, by W. A. Byrd, M. D., Illinois.

Surgical Treatment of Intestinal Obstruction, by Henry O. Marcy, M. D., Massachusetts.

Treatment of Fractures of the Long Bones, by James R. Taylor, M. D., New York.

Carbolic Acid and its relation to Surgical Therapeutics, by C. Truesdale, M. D., Illinois.

Appearance of the Diseased Mucous Membrane of the Nose and Throat of Adult Patients, by J. E. Rumbold, M. D., Missouri.

Is Abscission a proper Operation? by J. J. Chisholm, M. D., Maryland.

A Form of Spectacles in Lieu of Nose Pieces, by H. Culbertson, M. D., Ohio.

Nasal Disease the Frequent Cause of Asthma, J. O. Roe, M. D., New York.

Acute Lung Inflammation in Children under Six Years of Age, by A. Patton, M. D., Indiana.

Diphtheria, by W. F. Sharrer, M. D., Indiana.

Lupus of the Palate, by Carl Seiler, M. D., Pennsylvania.

Some Illustrative Cases of Tumors of the Mouth, by D. H. Goodwillie, M. D., New York.

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A GIGANTIC ELEPHANT at the Schoenbrunn Imperial Menagerie, near Vienna, was poisoned April 5th by command. Fifty grams of prussic acid were administered to him, after swallowing which he died in less than eight minutes.

MUSIC AS A THERAPEUTIC AGENT.—At the request of the chief medical officer of the military hospitals of Paris, a regimental band has been detailed to play at each of the three hospitals one day in the week for an hour. It is hoped and believed that the effect of the music will be to hasten the convalescence of the sick soldiers.

## Correspondence.

### THROMBUS OF THE VULVA.

*Editors Louisville Medical News:*

On Monday morning, April 21st, I was called in consultation with Dr. W. to consider the case of Mrs. W., multipara. The evening before she was delivered of a female child after a very short and easy labor. The only abnormal thing the attending physician noticed was an obliquity of the fetal head toward the left side. About midnight the lady had severe lancinating pains in the lower abdominal regions, which continued without abatement till morning. The doctor frankly confessed that he had no idea what was the matter. The nurse, an elderly woman of large experience, was thoroughly convinced that another child was awaiting help to enter the world.

After making a careful examination, I suggested the idea that it was a large thrombus of the right vulva. In this belief the doctor coincided. The tumor, though large, was not soft and fluctuating to the touch. We decided not to make an incision, but to adopt the expectant plan of treatment. Morphia was administered in full doses, and hot water applied every minute. The patient ceased her moaning, and became quite comfortable after the lapse of half an hour. The urine was drawn off with a catheter. In a week Dr. W. reported the tumor as somewhat smaller, but still a little painful. An ointment containing iodide of potash, stramonium, and camphor was applied with good results. The tumor is much smaller now, and the patient can urinate and walk about. Some years ago she fell on a chair-back and injured herself in the right groin.

LEVI CHASE.

IRWIN, KANSAS, May 26, 1883.

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*Editors of Louisville Medical News:*

I expect I can report a case of the youngest grandmother in this country. Mrs. C. was born 1854, married 1867; a daughter was born in ten months afterward. The daughter married in 1882, and in March of this year, I was with her at the birth of her nine-pound boy. The youthful grandmother, not quite twenty-nine years old, was also present.

R. S. STANLEY, M.D.

BOONEVILLE, MISS., May 28, 1883.



## Selections.

ON THE USE OF ANESTHETICS DURING LABOR. By Thos. D. Savill, M.D., London.

In opening this discussion, I will ask your attention to three questions:

*First.* What are the advantages and disadvantages of the use of anesthetics during normal labor?

*Second.* What are their advantages and disadvantages during abnormal labor?

*Third.* What is the best kind of anesthetic to use, and the best mode of administration?

1. In normal labor. Many years ago this subject had a moral aspect, and I am told that the question still exists in the minds of the laity, but we need scarcely stop to discuss it now. The pains of even healthy labor are in some cases very severe, producing at times what almost amounts to delirium. Are we not then justified in giving some form of anodyne, just as we would for a neuralgia? Provided we avoid certain risks, why should we not assuage the pain in the one as well as in the other? In these days of scientific medicine, when we are so far in possession of the knowledge of the conditions and sources of danger, we can with greater boldness employ agents for the relief of suffering, which, in darker times, we rightly hesitated to use even for the necessary treatment of disease. Moreover, pain is a depressing agent in itself, and lowers the vitality of the sufferer; and we ought on this account to relieve it where possible. Of course, it behooves us first to become acquainted with the risks we run, and to see that they are reduced to a minimum. But the relief of pain is not the only advantage which anesthetics have in normal labor, for they also obviate a tendency to certain complications. Rigidity of the cervix and other irregular uterine contractions, depending on functional causes, are less likely to occur when chloroform has been given even to a slight extent; and the indirect good thus done is equivalent to all the advantages of a speedy over a tardy labor. Again, in some women there is an inherent predisposition to puerperal convulsions, so justly dreaded by the obstetrician; and this tendency anesthetics will counteract by quieting the nervous system and abolishing the pain which acts as an exciting cause.

It is right, however, that we should bear in mind the objections that there are. The first, and indeed the only formidable one, is the tendency to produce *post-partum* hemor-

rhage. It is now well established that both ether and chloroform, when given to the full extent, produce great relaxation of the muscular tissues throughout the body—voluntary and involuntary. About the voluntary anyone can assure himself; and that the organic muscles also share in the general relaxation is evidenced by the diminished vermicular movements of the intestines of an animal after death; by the dilatation of the pupil which occurs after the initial stage of administration; and by the diminution and sometimes abolition of the uterine contractions which occur when the full effect of either of these drugs is induced. It is in this way that they hinder nature's method of closing the uterine sinuses after the separation of the placenta, and then flooding occurs. How to obviate this untoward result should be one of our chief aims when an anesthetic has been used.

By interfering with the uterine contractions before expulsion of the fetus, labor becomes somewhat prolonged. And further, all anesthetics (but especially ether) are apt to be attended with troublesome vomiting, and followed by headache and depression.

You will notice that all these evils arise from complete anesthesia. Partial anesthesia is not attended by them, if other conditions be favorable; and I believe it is this fact which will explain the discrepancy between some of the statements as to the effect of anesthetics on the uterine contractions.

2. Let us turn now to the case of abnormal labor. By that, I mean labor that is complicated in some way, or necessitating some form of operative interference.

Here, besides relieving pain, an anesthetic greatly facilitates manipulations of all sorts. That very relaxation which is otherwise an evil is here of great use; especially is it so in the operation of turning. Of all operations, perhaps it is more advantageous in cases of version than in any other; but at all times, whether for craniotomy, cephalotripsy, high forceps operation, or the introduction of the hand into the uterus, fully induced anesthesia gives great satisfaction to the operator and much ease to the patient, enabling her to undergo the operation without movement or shock. Again, besides obviating a tendency to the two complications—spasm of the cervix and puerperal convulsions—chloroform constitutes the best and speediest mode of treatment for both of these conditions when they arise; the first by relaxing tissue, and the second by abolishing the reflex excitability of the nervous system.

The disadvantages are, first, The great tendency to the production of *post-partum* hemorrhage as already mentioned; and second, a fresh one, in the way it muffles and obscures the pain, so that we can not tell the precise moment to aid nature with our efforts. This applies mainly to the group of forceps operations.

3. We now come to the question: What is the best anesthetic to use, and the method of its administration? The division of cases into normal and abnormal has a practical application; for, in normal cases it is given solely with the object of relieving pain, and it is quite unnecessary to push the anesthetic to loss of consciousness; but, in abnormal cases, besides relieving pain, it is given as part of the treatment, and complete anesthesia must be induced.

The best kind of anesthetic to use has hitherto been pretty well agreed upon; for, although many drugs have been suggested, chloroform has justly carried off the palm. Of the two commoner anesthetics, chloroform and ether, we know that whereas chloroform tends to produce death suddenly by cardiac paralysis or syncope, ether in most cases tends to death by choking up the lungs or larynx. In the fatal syncope of chloroform, all is over in a moment; artificial respiration or any thing else is of little or no avail. But, in the asphyxia of ether, by pulling the patient's tongue forward, rolling him over on his side, and lastly, by artificial respiration, we can almost always restore him. And this constitutes the only though great advantage of ether over chloroform in ordinary cases. But these arguments do not hold in labor, for it is now well known that chloroform has but little tendency to the production of fatal syncope in pregnant women; a fact which may be accounted for, partly by the cardiac hypertrophy that always accompanies pregnancy, and partly by the absence of any thing like terror in the excitement of the moment. On the other hand, the disagreeable irritation of the lungs which ether produces, and the struggling and length of time it takes to produce anesthesia (especially in unaccustomed hands) constitute very great objections to its use in parturition. Some, however, still prefer it, and no doubt it is of much value when, for some reason, chloroform can not be given. Methylene dichloride has been tried, and found wanting; and you will find the merits of nitrous oxide expounded by Dr. Macan in the Journal for February 2d of this year. Chloral is useful

during the first stage—at which time chloroform is not advisable—and is warmly supported by Dr. Playfair. Its action is the same as chloroform, and it is safer, but it is also much less speedy and efficacious.

The method of administration of chloroform must differ according to the purpose we have in view. If the relief of pain be our only object, its partial administration may be effected either by giving the crude drug in small quantities, or by diluting it to the appropriate strength with alcohol. This latter method has the advantages of being safer and more exact. The alcohol also, in some degree, counteracts the depressing influence of the chloroform. I believe the most convenient proportions to be equal parts by measure of chloroform and rectified spirit; and there are two small practical points worth noting, (1) the addition of some aromatic serves to make the mixture more agreeable, perhaps to prevent sickness and to avoid confusion with pure chloroform; (2) add the chloroform to the spirit, so as not to get a precipitate.

Concerning the inhaler, the simplest is the best. A perforated box with a pad of lint inside, or handkerchief folded, will do, or Skinner's inhaler and drop-bottle are convenient. There is no need for a special administrator in these cases; the patient can give it to herself. Direct her to take half a dozen deep inhalations, and then, as she becomes drowsy, the inhaler drops off and the administration ceases. A useful test of the effect produced is her power of conversation.

In normal cases chloroform should not be given in the first stage, when it materially interferes with the mechanical dilatation of the os. In the second stage it may be given at any time, and becomes especially necessary toward the end, as the head passes the vulva. Much of the success, or the reverse, depends on the precise moment at which the administration is stopped. If too early, the patient is unrelieved during the most painful period of the whole labor; if continued too long, you run the risk of hemorrhage. In the third stage it is not called for at all, except perhaps in some cases of retained placenta from hour-glass contractions.

In abnormal cases, where it is desirable to produce complete anesthesia, the crude drug must be administered; and it is of the utmost importance for one person to devote his attention entirely to the anesthetic. The mode of administration differs in no way

from ordinary cases, except perhaps for the length of time it may be given.

In conclusion, allow me to indicate by way of summary what I believe to be the main precautions, whose observance would render the use of chloroform perfectly justifiable:

1. There are certain women who have a tendency to flood at every confinement, and others in whom there seems an already too great relaxation of fiber—weak anemic females in their eighth or tenth confinement; and to these it would be unadvisable to give chloroform except for necessity. Happily, it is not these women who suffer the most pain, but rather those strong healthy primiparae whose pelves and general build approximate to the masculine type.

2. We should not give it when labor is complicated with severe vomiting, or with acute disease of the heart or lung, unless there be imperative calls for it.

3. It should not be given to the full extent except for operation, convulsions, or spasm of the cervix; and then it is most necessary that one person should devote his entire attention to it.

4. The inhalation should be stopped directly we find the pulse becoming very weak or the respiration irregular.

5. Any thing which makes us suspect a fatty or enfeebled cardiac wall should make us cautious in the use of chloroform. Here, as in cases other than those of labor, it is not the most extensive valvular disease (so long as it be attended by compensating hypertrophy), but the atrophied or degenerate wall that constitutes the source of danger. Unfortunately the signs of these conditions are subtle and uncertain; but a fatty heart may be suspected by an exceedingly feeble cardiac impulse combined with an almost inaudible first sound; or attacks of dyspnea, vertigo, and syncope, in the absence of anemia, or valvular lesion; or the copious deposit of fat in other parts of the body, and the occurrence of dropsy without adequate cause. A dilated heart may be suspected by increased area of precordial dullness combined with epigastric and venous pulsation, and a want of correspondence between the violence of the cardiac impulse and the strength of the pulse. Pericardial adhesions also form a great source of danger. They may be suspected when the heart's apex is fixed above its normal position and does not shift with respiration; or when there is depression instead of protrusion of intercostal spaces over the position of the apex,

giving a wavy character to the cardiac impulse.

6. The sixth and last precaution I would mention is this: In all cases we should take extra care to prevent the occurrence of hemorrhage after birth, by giving a full dose of ergot in a little warm water when the head reaches the perineum, by ceasing the chloroform immediately it is born, and by rousing the patient from her lethargy as soon as possible.

MIDLAND MEDICAL SOCIETY.—E. Malins, M.D., president, in the chair. (*British Med. Journal*).

*Hysterical Paraplegia.* Dr. Suckling told of a case of paraplegia in a woman, aged twenty-five, which he considered to be hysterical. During an attack of subacute rheumatism a sudden rise of temperature occurred, attended with complete spastic paraplegia; but in twenty-four hours the rigidity passed off and the patient was able to move about. There was ankle-clonus and an increase of patellar reflexes on both sides; also analgesia. Electrical sensibility had been found to vary considerably, the responses being normal.

*Hypertrophy of the Toe-nails.* Mr. Hugh Thomas exhibited two very long nails, removed from the great toes of a woman aged sixty-five. They had been allowed to remain uncut for eleven years. The right one measured five inches and a quarter, and passed under the four other toes; the left was three inches and three quarters in length and lay over the other toes of the foot. The patient was unable to walk. After the removal the matrix on both sides was found to be healthy.

*Double Placenta.* Mr. Thomas also showed a placenta, from a case of single birth, having a separate cotyledon imbedded in its membranes. Attached to it was a rudimentary cord inserted into the maternal end of the umbilical cord, suggesting the former existence of another fetus. During the whole period of pregnancy there was persistent vomiting. No *post-partum* hemorrhage took place.

*Empyema: Paracentesis.* Mr. Chavasse exhibited a child, seven years of age, upon whom he had performed paracentesis thoracis for empyema, by means of a double opening in the left eighth intercostal space. The child was lost sight of, but returned in four months with the drainage-tube *in situ* and lung collapsed. In a fortnight after the removal of the tube the wounds were

closed and the normal physical sign fully re-established.

**PENETRATING GUNSHOT WOUNDS OF THE ABDOMEN.**—Dr. Arthur H. Robinson describes two cases where a revolver-wound was received in almost the same anatomical locality, but with different results. J. T., aged thirty-six was admitted into the hospital on September 11, 1879. While examining a loaded revolver one of the barrels exploded, and the contents were lodged in his abdomen. He was brought some distance in a cab, and arrived at the hospital half an hour after the occurrence of the accident. He walked to his ward and was at once placed in bed. A clearly-cut linear wound with slightly inverted edges was found two inches below the umbilicus and two inches to the left of the middle line. The patient complained of considerable pain all over the abdomen; his skin was cold and moist, breathing short, pulse small and very rapid. A probe was cautiously passed into the opening, and it was at once deflected to the right in the direction of the umbilicus but, immediately before reaching that point, it was again suddenly deflected in the direction of the abdominal cavity, which it unmistakably entered. The most careful examination of the parietes failed to discover the further course of the bullet, and it was considered to have embedded itself in the liver. Thirty minims of tincture of opium with brandy and water were at once administered, given in small quantity and occasionally repeated. Vomiting of a bilious character came on shortly afterward, and, as the patient suffered severely from the abdominal pain, referred more particularly to the region of the liver, it was decided to place him thoroughly under the influence of morphia administered hypodermically. This was accordingly done. By September 17th his condition began to show signs of improvement, and on the 20th his bowels acted for the first time. On the 23d he was able to take fish to his dinner, and on the 29th he sat up out of bed. The wound which had required next to no attention was healed completely. A close examination of the parietes, more especially the lumbar region, was again made but without any positive result. He was discharged on the twenty-third day after the injury. He consulted Dr. Frederick Page very shortly afterward for an attack of vomiting, which was considered to be due to peritoneal irritation. This subsided, and in a few weeks

the man returned to his duties on board ship, and he has pursued them ever since (three and half years) without the least further intimation of the locality of the bullet's whereabouts.

Another case, in many respects similar to the first, came under Dr. Robinson's notice in 1880. This patient was a chimney-sweep, about twenty-eight years of age, and he had also been wounded in the abdomen by the accidental discharge of a revolver. On this man's admission into the hospital he was suffering severely from collapse. An opening was found in identically the same position as in the former case, that is two inches below the umbilicus and two to the left of the mid-line, but its edges were more contused and inverted. There was no hemorrhage externally and the wound was treated as in the previous case; indeed, the same general treatment was followed throughout. The parietes were carefully examined but the opening was not probed; the intense collapse rendering it almost certain that the ball had penetrated the abdominal cavity with the worst results. The pain was kept under by repeated hypodermic injections of morphia, but vomiting, generally bilious in character, remained persistently. On the seventh day after the injury he died. Dr. Robinson examined the body some hours afterward, and, before opening it, attempted to pass a long probe into the track of the bullet. The wound was completely healed, and almost immediately after breaking through the cicatrix some obstacle was encountered. On opening the body the obstacle proved to be the small intestine in one clotted mass, the coils being firmly held together by thick, tough lymph. No trace of the bullet's track could be found in this, and the most careful examination of the entire small and large intestine failed to discover any sign of injury done to those organs in the form of a perforation. Nor was there any trace of extravasation of their contents. The search was continued further, but beyond what appeared to be a graze on the right side of the body of the first lumbar vertebra, no trace of the bullet could be found in the abdominal organs or the lumbar muscles though, doubtless, it was embedded somewhere in the latter.—*British Med. Journal.*

THE head master of a boarding-school in England has been ordered to pay compensation to the amount of £15 to a boy on whose fingers he had inflicted permanent injury.